FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040394

Facility Name: GLENWOOD CARE CENTER

Address: 222 NORTH HAMMES (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

IDPA ID Number: 36-3873066

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,291	6,291	8
9	SNF/PED					9
10	ICF	40,593	3,065		43,658	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,593	3,065	6,291	49,949	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.41%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 6,016

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	193,091	16,613	16,783	226,487		226,487		226,487			1
2	Food Purchase		181,831		181,831	(17,903)	163,928	(420)	163,508			2
3	Housekeeping	186,218	26,733		212,951		212,951		212,951			3
4	Laundry	56,088	14,785		70,873		70,873		70,873			4
5	Heat and Other Utilities			170,127	170,127		170,127	52	170,179			5
6	Maintenance	123,605	20,428	40,950	184,983		184,983	7,215	192,198			6
7	Other (specify):*			12,642	12,642		12,642	40	12,682			7
8	**TOTAL General Services**	559,002	260,390	240,502	1,059,894	(17,903)	1,041,991	6,887	1,048,878			8
	B. Health Care and Programs											
9	Medical Director			8,900	8,900		8,900		8,900			9
10	Nursing and Medical Records	1,799,535	83,229	53,025	1,935,789		1,935,789	(18,592)	1,917,197			10
10a	Therapy	11,069	6,787	151,878	169,734		169,734	(2,835)	166,899			10a
11	Activities	88,779	10,608	16,495	115,882		115,882		115,882			11
12	Social Services	232,414			232,414		232,414		232,414			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,131,797	100,624	230,298	2,462,719		2,462,719	(21,427)	2,441,292			16
	C. General Administration											
17	Administrative	108,168			108,168		108,168	98,452	206,620			17
18	Directors Fees											18
19	Professional Services			251,444	251,444		251,444	(195,166)	56,278			19
20	Dues, Fees, Subscriptions & Promotions			23,415	23,415		23,415	2,195	25,610			20
21	Clerical & General Office Expenses	35,086	11,274	321,414	367,774		367,774	(214,551)	153,223			21
22	Employee Benefits & Payroll Taxes			430,128	430,128	17,903	448,031		448,031			22
23	Inservice Training & Education							1,358	1,358			23
24	Travel and Seminar			735	735		735	264	999			24
25	Other Admin. Staff Transportation			968	968		968	3,013	3,981			25
26	Insurance-Prop.Liab.Malpractice			85,326	85,326		85,326	1,529	86,855			26
27	Other (specify):*							59,155	59,155			27
28	**TOTAL General Administration**	143,254	11,274	1,113,430	1,267,958	17,903	1,285,861	(243,751)	1,042,110			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,834,053	372,288	1,584,230	4,790,571		4,790,571	(258,291)	4,532,280			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GLENWOOD CARE CENTER **#0040394** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,690	
	REPAIRS & MAINTENANCE		8,093	
			0	16,783
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		37,719	
	ELECTRICITY		90,321	
	WATER		42,087	
	CABLE TV - LOBBY		0	
			0	170,127
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,735	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,607	
	ELEVATOR MAINTENANCE & REPAIR		7,252	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,048	
	FIRE SERVICE		4,308	
			0	
			0	
			0	40,950
7	**OTHER**			
	SCAVENGER		12,322	
	SECURITY SERVICE		320	12,642
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,900	8,900

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		525	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,800	
	UTILIZATION REVIEW FEES	XVIII B __-2	50,000	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	700	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	53,025
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		6,120	
	SPEECH THERAPY SERVICES		1,166	
	OCCUPATIONAL THERAPY SERVICES		5,602	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	124,590	151,878
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		16,495	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	16,495
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GLENWOOD CARE CENTER **#0040394** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	25,185	
	ADMINISTRATIVE CONSULTANTS	XIX C	186,000	
	PROFESSIONAL FEES	XIX C	40,259	
			0	251,444
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	925	
	EMPLOYEE WANT ADS	XIX F	15,531	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	2,751	
	LICENSES & PERMITS	XIX F	3,435	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	123	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,415
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,843	
	OUTSIDE CLERICAL SERVICES		123,427	
	PENALTIES / OVERDRAFT CHARGES	VI 18	58,636	
	HOME OFFICE EXPENSE		116,584	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,924	
	MESSENGER SERVICE		0	
			0	321,414

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	211,631	
	UNEMPLOYMENT COMPENSATION	XIX D	80,287	
	WORKERS COMPENSATION INSURANCI	XIX D	53,964	
	HOSPITALIZATION INSURANCE	XIX D	57,124	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	25,622	
	CHICAGO HEAD TAX	XIX D	0	430,128
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	735	
	TRAVEL	XIX G	0	
			0	
			0	735
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		968	968
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		85,326	85,326
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,584,230

GLENWOOD CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	181,831	PATIENT MEALS	149847
LESS SALES TAX	(420)	ADD EMPLOYEE MEALS	16425
NET FOOD	181,411	TOTAL MEALS/YEAR	166272
TOTAL PATIENT CENSUS	49,949	NET FOOD	181411
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	166272
TOTAL PATIENT MEALS	149847	COST PER MEAL	1.09
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	17903
TOTAL EMPLOYEE MEALS	16425		

Facility Name & ID Number GLENWOOD CARE CENTER #0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,862	34,862		34,862	17,960	52,822			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,696	122,696		122,696	52,635	175,331			32
33	Real Estate Taxes			93,982	93,982		93,982		93,982			33
34	Rent-Facility & Grounds			629,376	629,376		629,376		629,376			34
35	Rent-Equipment & Vehicles			38,682	38,682		38,682	(11,607)	27,075			35
36	Other (specify):*											36
37	TOTAL Ownership			919,598	919,598		919,598	58,988	978,586			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		224,376	140,903	365,279		365,279	(14,286)	350,993			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		224,376	252,046	476,422		476,422	(14,286)	462,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,834,053	596,664	2,755,874	6,186,591		6,186,591	(213,589)	5,973,002			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,113	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(420)	2		13
14	Non-Care Related Interest	(14)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(58,636)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(925)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(123)	20		28
29	Other-Attach Schedule SEE PAGE 5A	529			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,126)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(157,463)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (157,463)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (213,589)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GLENWOOD CARE CENTER

ID# 0040394

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 529	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	529		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD CARE CENTER **#** 0040394 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(420)	0	0	0	0	0	0	0	0	0	0	(420)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	52	0	0	0	0	0	0	0	0	0	52	5
6	Maintenance	529	6,686	0	0	0	0	0	0	0	0	0	7,215	6
7	Other (specify):*	0	40	0	0	0	0	0	0	0	0	0	40	7
8	**TOTAL General Services**	109	6,778	0	0	0	0	0	0	0	0	0	6,887	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(18,592)	0	0	0	0	0	0	0	0	0	(18,592)	10
10a	Therapy	0	3,005	(5,840)	0	0	0	0	0	0	0	0	(2,835)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(15,587)	(5,840)	0	0	0	0	0	0	0	0	(21,427)	16
	C. General Administration													
17	Administrative	0	98,452	0	0	0	0	0	0	0	0	0	98,452	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(200,400)	5,234	0	0	0	0	0	0	0	0	(195,166)	19
20	Fees, Subscriptions & Promotions	(1,698)	0	3,893	0	0	0	0	0	0	0	0	2,195	20
21	Clerical & General Office Expenses	(58,636)	(238,384)	82,469	0	0	0	0	0	0	0	0	(214,551)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,358	0	0	0	0	0	0	0	0	1,358	23
24	Travel and Seminar	0	0	264	0	0	0	0	0	0	0	0	264	24
25	Other Admin. Staff Transportation	0	0	3,013	0	0	0	0	0	0	0	0	3,013	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,529	0	0	0	0	0	0	0	0	1,529	26
27	Other (specify):*	0	0	59,155	0	0	0	0	0	0	0	0	59,155	27
28	**TOTAL General Administration**	(60,334)	(340,332)	156,915	0	0	0	0	0	0	0	0	(243,751)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(60,225)	(349,141)	151,075	0	0	0	0	0	0	0	0	(258,291)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,113	0	13,847	0	0	0	0	0	0	0	0	17,960	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14)	0	52,649	0	0	0	0	0	0	0	0	52,635	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	(11,607)	0	0	0	0	0	0	0	0	(11,607)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	4,099	0	54,889	0	0	0	0	0	0	0	0	58,988	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(14,286)	0	0	0	0	0	0	0	0	(14,286)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(14,286)	0	0	0	0	0	0	0	0	(14,286)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,126)	(349,141)	191,678	0	0	0	0	0	0	0	0	(213,589)	45

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB.	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	HOME OFFICE EXPENSE	$ 116,584	CAREPLUS MANAGEMENT, INC		$	$ (116,584)	1
2	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	2
3	V	21	CLERICAL FEES	121,800	" "			(121,800)	3
4	V	19	ADMIN. CONSULT FEES	186,000	" "			(186,000)	4
5	V	10	MEDICARE CONSULT. FEES	50,000				(50,000)	5
6	V								6
7	V	5	UTILITIES		" "		52	52	7
8	V	6	MAINT & REPAIRS		" "		2,488	2,488	8
9	V	6	MAINTENANCE SALARIES		" "		4,198	4,198	9
10	V	7	SECURITY		" "		40	40	10
11	V	10	NURSING SALARIES		" "		31,408	31,408	11
12	V	10A	THERAPY SALARIES		" "		3,005	3,005	12
13	V	17	ADMIN SALARIES		" "		98,452	98,452	13
14	Total			$ 488,784			$ 139,643	$ * (349,141)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 151,878	CAREPLUS REHABILITATIVE SERVICES		$ 146,038	$ (5,840)	15
16	V	39	ANCILLARY THERAPY	140,903	" "		126,617	(14,286)	16
17	V	35	EQUIPMENT RENT	18,648	" "			(18,648)	17
18	V	30	SL DEPRECIATION		" "		3,106	3,106	18
19	V	32	INTEREST		" "		2,180	2,180	19
20	V								20
21	V								21
22	V								22
23	V	19	PROFESSIONAL FEES		CAREPLUS MGMT, INC.		5,234	5,234	23
24	V	20	ADVERTISING		" "		3,893	3,893	24
25	V	21	TOTAL OFFICE		" "		30,780	30,780	25
26	V	21	CLERICAL SALARIES		" "		51,689	51,689	26
27	V	23	SEMINARS		" "		1,358	1,358	27
28	V	24	TRAVEL		" "		264	264	28
29	V	25	TRANSPORTATION		" "		3,013	3,013	29
30	V	26	INSURANCE		" "		1,529	1,529	30
31	V	27	EMPLOYEE BENEFITS		" "		59,155	59,155	31
32	V	30	DEPRECIATION (SL)		" "		10,741	10,741	32
33	V	32	INTEREST		" "		50,469	50,469	33
34	V	35	EQUIPMENT RENT		" "		7,041	7,041	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 311,429			$ 503,107	$ * 191,678	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN.FINANC	25.32	SEE ATACHED	5.4		SALARY	18,040	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSUL	24.88	SCHEDULE	5.4		SALARY	18,040	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.99		5.4		SALARY	11,646	17-7	4
5	JANICE L. CLAFFORD	CONTROLLER	CLERICAL	0.55		5.4		SALARY	5,733	17-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	0.49		5.4		SALARY	1,506	10-7	6
7	JAMME O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		5.4		SALARY	11,500	17-7	7
8	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		5.4		SALARY	7,224	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 73,689		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	UTILITIES	CENSUS DAYS	553,765	13	574		49,949	52	2
3	6	MAINT & REPAIRS	CENSUS DAYS	553,765	13	27,588		49,949	2,488	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	553,765	13	46,540	46,540	49,949	4,198	4
5	7	SECURITY	CENSUS DAYS	553,765	13	444		49,949	40	5
6	10	NURSING SALARIES	CENSUS DAYS	553,765	13	348,203	348,203	49,949	31,408	6
7	10A	THERAPY SALARIES	CENSUS DAYS	553,765	13	33,317	33,317	49,949	3,005	7
8	17	ADMIN SALARIES	CENSUS DAYS	553,765	13	1,091,504	1,091,504	49,949	98,452	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	553,765	13	58,031		49,949	5,234	9
10	20	ADVERTISING	CENSUS DAYS	553,765	13	43,163		49,949	3,893	10
11	21	TOTAL OFFICE	CENSUS DAYS	553,765	13	341,243		49,949	30,780	11
12	21	CLERICAL SALARIES	CENSUS DAYS	553,765	13	573,059	573,059	49,949	51,689	12
13	23	SEMINARS	CENSUS DAYS	553,765	13	15,061		49,949	1,358	13
14	24	TRAVEL	CENSUS DAYS	553,765	13	2,923		49,949	264	14
15	25	TRANSPORTATION	CENSUS DAYS	553,765	13	33,401		49,949	3,013	15
16	26	INSURANCE	CENSUS DAYS	553,765	13	16,951		49,949	1,529	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,765	13	655,825		49,949	59,155	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	553,765	13	119,076		49,949	10,741	18
19	32	INTEREST	CENSUS DAYS	553,765	13	559,538		49,949	50,469	19
20	35	EQUIPMENT RENT	CENSUS DAYS	553,765	13	78,057		49,949	7,041	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,044,498	$ 2,092,623		$ 364,809	25

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB BANK		X	CAPITAL IMPROVEMENTS	$2,532.89	01/04	$ 336,000	$ 59,260	01/09	PRIME+	$ 5,048	1
2												2
3												3
4												4
5	CAREPLUS MANAGEMENT ALLOCATION:LOC,ETC										50,469	5
	Working Capital											
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	1,233,544		PRIME+	117,244	6
7	A.I. CREDIT INC		X	INSURANCE FINANCED							404	7
8	CAREPLUS REHAB ALLOCATION:EQUIPMENT LOANS										2,180	8
9	TOTAL Facility Related				$2,532.89		$ 1,636,000	$ 1,292,804			$ 175,345	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,636,000	$ 1,292,804			$ 175,345	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD CARE CENTER **#** 0040394 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	88,892	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	90,982	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,090	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	91,892	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	93,982	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	79,467	8
2001	82,562	9
2002	88,330	10
2003	88,012	11
2004	90,982	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD CARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040394

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-304-025-0000	NURSING HOME	$ 90,981.84	$ 90,981.84
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 90,981.84	$ 90,981.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,625		$	1
2					2
3	TOTALS	75,625		$	3

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	1,080	34	31.5	34		432	9
10	LEASEHOLD IMPROVEMENTS			1993	26,757	686	39	686		8,537	10
11	LEASEHOLD IMPROVEMENTS			1994	4,980	128	39	128		1,509	11
12	OUTLETS			1995	1,429	37	39	37		381	12
13	PAVING			1995	19,500	1,300	15	1,300		13,656	13
14	ROOF REPAIR			1996	2,505	64	39	64		632	14
15	ELEVATOR REPAIR			1996	7,000	180	39	180		1,756	15
16	WATER CONDITIONING SYSTEM			1996	3,486	89	39	89		864	16
17	ROOFTOP A/C UNIT			1996	5,300	136	39	136		1,230	17
18	LANDSCAPING			1996	3,554	237	15	237		2,251	18
19	EXTERIOR PLASTER/PAINT			1997	8,500	218	39	218		1,917	19
20	PLUMBING			1997	1,091	28	39	28		242	20
21	LAMINATED COUNTER TOPS			1997	5,900	151	39	151		1,238	21
22	WALK-IN COOLER			1998	9,893	254	39	254		2,021	22
23	OUTDOOR STORAGE UNIT			1998	1,200	31	39	31		244	23
24	DRAIN LINE REPAIRS			1998	6,575	168	39	168		1,308	24
25	ROOFTOP HEAT / AC UNIT			1998	5,200	133	39	133		959	25
26	LANDSCAPING			1998	5,883	392	15	392		2,940	26
27	ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE			1999	17,798	456	39	456		2,818	27
28	NEW SUSPENDED CELLING			2000	64,670	2,352	27.5	2,352		13,725	28
29	CARPET-ENTRANCE & LOBBY			2000	2,750	240	20	138	(102)	828	29
30	NEW DIALYSIS ROOM			2001	8,750	318	27.5	318		1,550	30
31	INSTALLATION WATER SYSTEM			2001	1,905	69	27.5	69		337	31
32	FIRE ALARM SYSTEM-NEW HORNS,SMOKE DETECTORS			2001	7,194	262	27.5	262		1,124	32
33	DRYWALL			2001	5,425	197	27.5	197		846	33
34	PASSENGER ELEVATOR-PUMPING UNIT			2001	9,700	353	27.5	353		1,427	34
35	REPLACE WATER HEATER			2001	4,411	160	27.5	160		647	35
36	ROOF REPAIR			2002	3,100	113	27.5	113		428	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSES STATION WITH SURFACE TRANSACTION TOP	2002	$ 17,820	$ 648	27.5	$ 648	$	$ 2,079	37
38	VESTIBULE, LOBBY,DINING ROOMS - WALLCOVERING	2002	7,200	262	27.5	262		978	38
39	REPLACE THE ELEVATOR PUMPING UNIT	2002	4,700	171	27.5	171		648	39
40	NURSES' STATIONS-WALLCOVERING, ELECTRIC. WORK	2002	5,440	198	27.5	198		667	40
41	REPAIR PATCH AT FRONT OF BUILDING	2002	1,720	115	15	115		460	41
42	BUILD NEW WALL BETWEEN LOBBY & NURSES STATION	2002	6,930	252	27.5	252		830	42
43	LOBBY, VESTIBULE, CORRIDOR-FLOORING	2002	34,654	1,260	27.5	1,260		4,043	43
44	FACILITY DOOR	2003	3,072	112	27.5	112		284	44
45	GREASE TRAPS	2003	3,900	141	27.5	141		359	45
46	DELAYS FOR PATIO DOORS	2003	3,049	111	27.5	111		282	46
47	FENCE	2003	3,950	263	15	263		658	47
48	ROOF DRAIN	2003	1,900	69	27.5	69		147	48
49	FIRE ALARM SYSTEM	2003	6,198	225	27.5	225		478	49
50	INSTALL FIRE ALARM DEVICES	2005	6,662	232	27.5	232		232	50
51	REPLACE ROOF TOP UNIT	2005	11,450	191	27.5	191		191	51
52	SIDE WALK	2005	19,550	434	15	1,303	869	1,303	52
53	FURNISH AND INSTALL CEILING LIGHT FIXTURE	2005	6,150	9	27.5	9		9	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62	RELATED PARTY ALLOCATION:								62
63	CAREPLUS MGMT								63
64	BUILDING-TAG-18 PROPERTIES	2004	56,460	1,448	39	1,448			64
65	BUILDINF IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,181	854	39	854			65
66									66
67	CAREPLUS REHAB								67
68	GENERATOR	2003	24,048	617	39	617			68
69									69
70	TOTAL (lines 4 thru 69)		$ 492,570	$ 16,398		$ 17,165	$ 767	$ 79,495	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 235,846	$ 14,005	$ 20,616	$ 6,611	5-15	$ 139,681	71
72	Current Year Purchases	29,259	5,852	1,463	(4,389)	10	1,463	72
73	Fully Depreciated Assets	13,301					13,301	73
74	RELATED PARTY SL DEPRECIATION		10,928	10,928				74
75	TOTALS	$ 278,406	$ 30,785	$ 33,007	$ 2,222		$ 154,445	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1998 CHEVROLET VAN	2001	$ 13,250	$ 1,526	$ 2,650	$ 1,124	5	$ 13,250	76
77										77
78										78
79										79
80	TOTALS			$ 13,250	$ 1,526	$ 2,650	$ 1,124		$ 13,250	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 784,226	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 48,709	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,822	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,113	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 247,190	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF JOLIET

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	203	04/01/93	$ 629,376	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 629,376 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 38,682 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 72,657	$		$ 72,657	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,584			1,584	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			66,325			66,325	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				223,689		223,689	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-3				337			337	12
13	MEDICAL SUPPLIES Other (specify): LABORATORY	39-2 39-2					111 576		111 576	13
14	TOTAL			$		$ 140,903	$ 224,376		$ 365,279	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD CARE CENTER **#** 0040394 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (356,348)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 70,628)	2,116,058		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,875		6
7	Other Prepaid Expenses	40,524		7
8	Accounts Receivable (owners or related parties)	720,518		8
9	Other(specify): Real Estate Tax Escrow	58,559		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,649,186	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	389,881		15
16	Equipment, at Historical Cost	291,656		16
17	Accumulated Depreciation (book methods)	(331,083)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): RENT SECURITY DEPOSIT	487,200		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 837,654	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,486,840	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 775,459	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,928		28
29	Short-Term Notes Payable	2,035,027		29
30	Accrued Salaries Payable	198,918		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,786		31
32	Accrued Real Estate Taxes(Sch.IX-B)	91,892		32
33	Accrued Interest Payable	8,244		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,176,254	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,176,254	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 310,586	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,486,840	$	48

***(See instructions.)**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (101,871)	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(70,623)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (172,494)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	483,080	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 483,080	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 310,586	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,669,657	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,669,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,669,671	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,059,894	31
32	Health Care	2,462,719	32
33	General Administration	1,267,958	33
	B. Capital Expense		
34	Ownership	919,598	34
	C. Ancillary Expense		
35	Special Cost Centers	365,279	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,186,591	40
41	**Income before Income Taxes (line 30 minus line 40)****	483,080	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 483,080	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,545	2,586	$ 85,494	$ 33.06	1
2	Assistant Director of Nursing	961	984	28,907	29.38	2
3	Registered Nurses	20,870	21,700	649,017	29.91	3
4	Licensed Practical Nurses	14,486	15,089	343,265	22.75	4
5	CNAs & Orderlies	66,684	70,011	674,034	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,220	1,258	11,069	8.80	8
9	Activity Director	1,551	1,552	18,370	11.84	9
10	Activity Assistants	8,782	9,066	70,409	7.77	10
11	Social Service Workers	9,379	9,963	232,414	23.33	11
12	Dietician					12
13	Food Service Supervisor	2,396	2,470	41,338	16.74	13
14	Head Cook	6,648	7,092	66,027	9.31	14
15	Cook Helpers/Assistants	11,477	11,795	85,726	7.27	15
16	Dishwashers					16
17	Maintenance Workers	12,689	13,235	123,605	9.34	17
18	Housekeepers	19,322	20,451	186,218	9.11	18
19	Laundry	5,796	6,443	56,088	8.71	19
20	Administrator	2,076	2,306	68,856	29.86	20
21	Assistant Administrator	870	943	39,312	41.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,146	3,296	35,086	10.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,924	2,025	18,818	9.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,822	202,265	$ 2,834,053 *	$ 14.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,690	1-3	35
36	Medical Director	O	8,900	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,800	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	0	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PSYCHIATRIC	E	700	10-3	46
47	UTILIZATION REVIEW FEES	S	50,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 84,490		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TAMARA STONEBERGER	ADMIN	0	$ 68,856
PETER GENTILE	ASST ADMIN	0	24,767
RAFI ZIMMERMAN	ASST ADMIN	0	14,545
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,168

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		251,444
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 251,444

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 53,964
Unemployment Compensation Insurance		80,287
FICA Taxes		211,631
Employee Health Insurance		57,124
Employee Meals		17,903
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,500
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		25,622
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 448,031

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,531
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,048
TRUST/FRANCHISE/CONTRIB/ETC	650
LICENSES & PERMITS	3,435
DUES & SUBSCRIPTIONS	2,751
MGMT CO ALLOCATION	3,893
TRUST/FRANCHISE/CONTRIB/ETC	(650)
Less: Public Relations Expense	(0)
Non-allowable advertising	(925)
Yellow page advertising	(123)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,610

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	264
Seminar Expense	
	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	2002	$ 3,172	3 YRS	$ 529	$ 1,057	$ 1,057	$ 529	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,172		$ 529	$ 1,057	$ 1,057	$ 529	$	$	$	$	$

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,998** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **111,143**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,903** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees